Proof of Loss Accident Claim Form

Life Insurance Company of North America

CIGNA

MAIL TO: CIMA
1800 N. Beauregard St., Suite 100
Alexandria, VA 22311

INQUIRIES TO: Phone: (703) 739-9300
Toll Free: 1-800-468-4200
Fax: (703) 739-0761
E-mail: volunteers@cimaworld.com

CLAIMS ADMINISTERED BY: Preferred Care, Inc.
Fort Washington, PA

Check One:

☐ CNS/RSVP (SPS 900302) ☐ CNS/SCP ☐ CNS/FGP ☐ VIS (SPS 900303) ☐ CRASVP (SPS 900304) ☐ WRVP (SPS 900305)

CAUTION: Any person who, knowingly and with intent to defraud, or help commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. Residents of the following states, please see reverse side: ***California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas and Virginia.***

INSTRUCTIONS: The policy is Full Excess only. Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company. When you receive their Benefits Statement (Explanation of Benefits or EOB) send it to us along with itemized bills.

- **Part I -** Must be completed by the Sponsoring Organization.
- **Part II -** Must be completed by the Volunteer/Patient.
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits (EOB), additional bills with record of payment or denial from primary insurance carrier, including any Medicare payment records.

PART I - POLICYHOLDER REPORT

Name of Sponsor			Client Code	
Address *(Street, City, State, Zip)*				
Sponsor Contact	Phone ( )	Fax ( )	E-Mail	
Name of Volunteer: Last Name First Name		Social Security No.	Date of Birth	Sex ☐ M ☐ F
Nature of Injury (Describe fully, indicating what part of body was injured - e.g. broken arm, sprained ankle)				
Describe how the Accident occurred - provide all details. Attach a separate sheet, if necessary. **MUST BE A BODILY INJURY DUE TO ACCIDENT.**				
Describe activity Volunteer was engaged in at time of accident.				
Date of Accident	Place of Accident	Time of Accident _____ ☐ AM ☐ PM	First treatment date	
Name and Title of person supervising volunteer activity.			Was he or she a witness? ☐ Yes ☐ No	
List anyone present at the time of the accident.				
Please indicate to whom payments are to be made:				

Signature of Authorized Sponsoring Organization's Representative / Title **Date**

PART II - TO BE COMPLETED BY VOLUNTEER

Address of Volunteer *(Street, City, State, Zip Code)*

Telephone Number ( )	E-mail Address

Does Volunteer have health insurance other than Medicare?
☐ Yes ☐ No If Yes, please identify. _____

Is Volunteer covered by Medicare - Part A? ☐ Yes ☐ No Medicare - Part B? ☐ Yes ☐ No
Please attach bills and/or Medicare Explanation of Benefits.

NOTE: Without a complete answer to these questions, your claim cannot be processed.

Is the Volunteer enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (front and back).

Preferred Provider Organization (PPO) or similar prepaid health plan ☐ Yes ☐ No
If Yes, name of PPO or Organization _____

Health Maintenance Organization (HMO) or similar prepaid health plan ☐ Yes ☐ No
If Yes, name of HMO or Organization _____

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail will be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any CIGNA company, the Plan Administrator or their employees and authorized agents for the purpose of validation and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photocopy of the original shall be valid for the duration of this claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless otherwise specified above.

Volunteer's Signature / Date